TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ikechukwu Obih J MD

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-17-0854-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance of TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $939.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I have attached the EOB's that show an additional recommended payment of $881.22 that was processed on 12/17/2016 to Ikechukwu Obih, MD."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2016	99204, 95866, 95911, A4556	$939.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   Explanation of benefits processed December 17, 2016
   - 1 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day
   - 2 – Additional payment made on appeal/reconsideration
   - 3 – Workers' compensation jurisdictional fee schedule adjustment
   - 4 – The charge for the procedure exceeds the amount indicated in the fee schedule
   - 5 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 6 - The payment for this service is bundled into payment of other services

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Are the electrodes separately payable?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of $939.26. The respondent states, "The Carrier is issuing a check in the amount of $881.22 to Dr. Ikechukwu Obih, MD…"

   Review of the submitted documentation found an explanation of benefits dated December 17, 2016 for the stated amount. The Maximum Allowable Reimbursement for the services in dispute will be reviewed per the applicable fee guideline of 28 Texas Administrative Code §134.203 (c) (1) which states in pertinent part,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

Date of service	Amount Billed	Submitted Code	Units	Allowable	Calculation of MAR (DWC conversion factor/Medicare conversion factor) x Allowable = Texas Fee MAR	Amount paid by Carrier
June 11, 2016	$251.26	99204	1	$159.03	(56.82/35.8043) x $159.03 = $252.37	$251.26
June 11, 2016	$275.88	95886	2	$87.31	(56.82/35.8043) x $87.31 = $138.55x 2 units = $277.11	$275.88
June 11, 2016	$395.22	95911	1	$223.12	(56.82/35.8043) x $223.12 = $354.08	$354.08
				Total	$883.56	$881.22

Per Texas Administrative Code §134.203 (h),

> When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the **least** of the:
>
> (1) MAR amount;
>
> (2) health care provider's usual and customary charge

Therefore, as the billed amount for Codes 95886 and 99204 is less than the MAR calculation, the above the provider's usual and customary charge is the reimbursable amount.

Therefore, the Division finds no additional payment is due.

2. The carrier denied code A4556 – "electrodes" as 6 – "The payment for this service is bundled into payment of other services." Review of the service in disputes status code is "P" or "bundled/excluded codes." Therefore, the carrier's denial is supported no additional payment is recommended.
3. Review of the submitted information and applicable Division rules finds the carriers payment of the services in dispute are per fee guidelines.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		January 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.